TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
William D. Strinden, M.D.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-16-3106-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "You denied payment for the form stating that there was no documentation. Texas Division of Workers Compensation Rule 129.5 specifically states that the form shall be completed by treating doctor and it **does not** have to be attached to the claim if it was previously submitted."

Amount in Dispute: $15.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Audit makes recommendations based on supporting submitted information, which audit has not received for review.

Of note, a patient history search was performed in an effort to look for the fax'd form, nothing found."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 29, 2016	Work Status Report	$15.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §129.5 sets out the procedures for work status reports.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 11 – (112) Service not furnished directly to the patient and/or not documented.
   - B1 – (B12) Services not documented in patients' medical records.

Issues

Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code 11 – "(112) SERVICE NOT FURNISHED DIRECTLY TO THE PATIENT AND/OR NOT DOCUMENTED," and B1 – "(B12) SERVICES NOT DUCMENTED IN PATIENTS' MEDICAL RECORDS." The requestor argues that "Rule 129.5 specifically states that the form shall be completed by treating doctor and it **does not** have to be attached to the claim if it was previously submitted." The requestor asserts that he faxed the documentation in question to the adjuster on February 29, 2016.

28 Texas Administrative Code §133.307(c)(2) requires that requests for medical fee dispute resolution include:

(M) a copy of all applicable medical records related to the dates of service in dispute;
(N) a position statement of the disputed issue(s) that shall include:
  (i) the requestor's reasoning for why the disputed fees should be paid or refunded,
  (ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and
  (iii) how the submitted documentation supports the requestor's position for each disputed fee issue;

Review of the submitted information does not find support for a previous submission of the work status report. For this reason, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	July 27, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.